Department of Veterans Affairs
Medical Center
One Veterans Drive
Minneapolis, MN 55417

September 3, 2003

Testimony for the Capital Asset Realignment for Enhanced Services (CARES) Hearing at the Minneapolis Veterans Affairs Medical Center

Good morning, my name is Dr. Mary Lawrence. I am a staff Ophthalmologist here at the Minneapolis VA Medical Center. This morning I am submitting testimony both as an individual physician and as a representative of the Physicians Association of the Minneapolis Veterans Affairs Medical Center. In the next few minutes, I would like to address three issues that I feel are important for the implementation of the CARES proposal for the "Minnesota Market" of Network 23. Two issues address the impact of CARES on our veterans' access to medical care—the first is access to primary care, the second is access to specialty care. The third topic is the problem of medical provider staffing.

First, I'll address the Impact of CARES on Access to Primary Care in the "Minnesota Market".

After careful review of the recommendations for the CARES Program, I feel that the suggested plans for the "Minnesota Market", which includes 58 counties in Minnesota and 15 counties in Wisconsin, will greatly improve geographic access for our veterans to medical care. An important component of the proposal for the "Minnesota Market" is to increase primary care at the main facilities and to open 4 additional Community Based Outpatient Clinics (CBOC's). These are to be located in rural Minnesota and western Wisconsin. By locating the CBOC's closer to population centers where enrolled veterans live, the geographic access for our patients to primary care will, undoubtedly, be improved.

Currently, approximately 20% of the total veteran population is "enrolled" in the VA Medical Care System. Projections for the next one to two decades estimate that this percentage will rise only slightly. The Advanced Clinical Access Program, an initiative that is currently being implemented throughout the entire VA system, is reducing the waiting times for all clinic appointments. A result of the "Minnesota Market" becoming more accessible, both in terms of geography and clinical waiting times, will be a high likelihood of attracting more eligible veterans, causing an increase in the percentage of users, above that which is projected by the CARES data.

The CARES program will truly enhance geographic access of veterans in the Minnesota Market. Delivering better care may, however, translate into increased demand for our services.

Impact of CARES on Access to Specialty Care in the "Minnesota Market"

The second issue I would like to address is veterans' access to specialty care. A recent study appearing in last month's issue of the *Annals of Surgery* (http://www.annalsofsurgery.com/) predicts a 14 to 47 percent increase in the amount of work in all surgical fields over the next several years due to the "aging of America". The veteran population, likewise, is expected to be older and to have more medical problems over the next 10 to 20 years. As the primary care providers--through their excellent work--increase the longevity of our veterans, there will be increased demand for specialty care services such as cardiology, orthopedics, and

ophthalmology. Patients who, in past years, did not live to be old enough to develop cataracts and glaucoma, or to sustain a hip fracture, are now living to an age where these specialty diseases are prevalent and require treatment to maintain a good quality of life. A linear increase in primary care may translate into an exponential increase in specialty care. With a greater than 40% projected increase in outpatient primary care projected over the next 10 years, I am very concerned that the projected increase in specialty care (of just over 40%) is far too low. The VA needs to develop strategies to manage the increased demand for specialty care without sacrificing quality of care. Programs to increase the number of specialists or to increase the efficiency of specialists will be become more important. Initiatives such as the telemedicine programs, like the tele-ophthalmology and tele-dermatology programs which utilize digital photography and advanced telecommunication technology should be developed and implemented throughout the VA. Telemedicine requires capital investment and has the advantage of making specialists both more accessible to rural veterans, and more efficient. Programs such as this should be given high priority for capital expenditure and staffing resources.

Provider Staffing for the VHA

The third issue I'd like to touch on this morning is medical provider staffing. It is critical to recruit and retain high quality health care providers—talented doctors and dentists—who will be able to make correct diagnoses and deliver effective state-of-the-art treatments. In the proposed "Minnesota Market" plan, we will need more primary care providers as well as specialists. Let me address the issue of primary care providers first.

Over the past 10-15 years, residency programs throughout the country, and specifically here in Minnesota and Wisconsin, have increased the number of physicians they are training for primary care. Because of this fact, I do not have concerns about the *number* of primary care providers that could be hired to the staff the 4 additional CBOC's and the additional primary care suggested for the medical centers in the "Minnesota Market".

My major concern is *compensation* for our physicians and dentists. With the "graying of America", there will be increased demand for medical provider services in the private sector, making it more difficult for the VA to attract and keep high quality health care providers. The Secretary of Veterans Affairs, Anthony J. Principi, has recently proposed to Congress that a change be made in the pay system for physicians and dentists in the VA. I believe that compensation is critical for the recruitment and retention of good doctors. Although the CARES proposal is focused on capital assets, providers are the key to making it happen. A beautiful new CBOC without doctors to care for the patients will do no good.

Specialists will be even more difficult for the VA to recruit and retain. There are fewer of them and there is a growing demand for their work in the private sector that pays them better. The only way to adequately staff the changes that are proposed in the CARES program, is to improve the compensation program for all physicians. That includes the primary care providers who are caring for the patients as well as the specialists who help and support the primary care providers by placing all the pacemakers, performing all the spinal cord surgeries, and removing all the cataracts for their patients.

Everyone in this room this morning must do all they can to help Secretary Principi convince Congress to offer all physicians and dentists who work in the VA "market-sensitive pay". Good physicians are critical to providing good medical care.

Summary

The VA is the largest integrated healthcare system in the United States. Currently, I believe, we are providing excellent health care to our veteran population. But, we need to plan for the expected changes in the veterans' need for high quality medical care as we move into the next decade and beyond. The National CARES plan, a landmark program to study and implement a strategy to improve the VA health care infrastructure, provides a roadmap for making the capital changes necessary to preserve the

VA's ability to care for our veterans. Every veteran (and for that matter every taxpayer) in this great country of ours, deserves efficient utilization of the capital assets that have been appropriated for health care.

The suggested CARES program for the "Minnesota Market" will truly enhance the health care of veterans in Minnesota and western Wisconsin. Delivering better care is very likely, however, to translate into increased demand for our medical care services. In addition, the VA needs to develop strategies for the specialty care services to staff and manage an increased workload without sacrificing quality of care. And finally, the only way to adequately staff the primary care increases that are proposed for the "Minnesota Market" of the CARES program, is to improve the compensation program for the physicians and dentists who serve their country by working at the VA.

Many thanks for your kind attention this morning.

Respectfully submitted,

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CAPITAL ASSET REALLIGNMENT FOR ENHANCED SERVICES

My name is Katherine J. Maynard. Thank you for giving me the opportunity to verbally express to this CARES Commission, the opinions of the Bargaining Unit Employees that I represent, as a Local President of the American Federation of Government Employees (AFGE). I was born in rural North Dakota and was raised in Western SD. My Father and one of my uncles are veterans who receive care at Ft. Meade. My husband is a veteran, but is ineligible because of household income. My Father-in-law was treated at Ft. Meade and after he died there, was buried in the National Cemetery. My Mother-in-law is a former employee, who was medically retired from Ft. Meade. Many of the employees who work at small rural facilities are veterans themselves or have veteran relatives who receive treatment. I started working for the Department of Veterans Affairs (VA) at Ft. Meade, SD, before our secretary was elevated to Cabinet Level. The years since 1979 have brought many changes to the VA. Some good, some not so good and some very bad.

CARES originally appeared to be one of those good ideas. It seemed a noble and honorable concept! Why should the VA waste huge sums of money supporting buildings that are not being used for taking care of veterans? After all, that is our main mission, to care for veterans! If CARES merely got rid of buildings that were not used at all for veteran care, then it would remain a good idea. Unfortunately, CARES will also eliminate the underused buildings. That is where it crosses into the realm of bad ideas. The rural areas of SD, ND, NE, IA and MN do not have large enough populations to keep our buildings at full capacity. Does that mean our veterans do not deserve the care that they were promised when they stepped forward to serve their country during WWII, Korea, Vietnam and now the Middle East! Rural areas provided proportionally more volunteers in the Service, than any urban areas. Rather than providing that promised care, the VA seems determined to come up with new plans to circumvent that responsibility. The VA discontinued care to Category 8 Veterans. Now we have CARES to shut down all the facilities that are not operating with a waiting list. It's a "Catch 22"! VA Leadership insists that waiting lists must be pared down, but if a facility does not have a waiting list, it apparently is underused! Veterans in the rural areas deserve care equally as much as their urban comrades.

I am a member of the Veterans Integrated Service Network (VISN) 23 CARES Steering Committee. From the very beginning, the data that would be used for making important decisions about the location of future populations and the divestment or destruction of property was very troubling. Two facilities in Western SD, Ft. Meade and Hot Springs VA Medical Centers integrated in 1996, to become the VA Black Hills Healthcare System. During that process, we became aware of how different the data could be input by two different sites. That was two sites only 90 miles apart, both were rural and had a lot of contact with each other. When you determine actions, using comparisons based on data that is input differently, it's like comparing apples to oranges. You can not make reliable predictions based on Decision Support Service (DSS) data that is input differently around the country. Some of the blatant data errors included a map that showed a VA facility in Shannon County of South Dakota and all of the Residential Substance Abuse Treatment (RSAT) that had been done at the Ft. Meade Facility was credited to the Hot Springs site. If there were equal or greater data errors in the information that was given to each VISN for CARES planning, it is staggering to consider the amount of incorrect numbers that were probably used! CARES data indicates that a VA facility is not utilized enough in Western South Dakota. So, where will our veterans receive care? CARES data indicates that veteran care should be contracted out to local hospitals, so that the VA does not have to maintain underused facilities. Only question then, where are those local hospitals? Hot Springs SD doesn't have a community hospital. Most of the little towns in Western SD and surrounding states do not have community hospitals. If our veterans are forced to seek treatment at the bigger regional hospitals, they can not get the specialized care that VA has traditionally provided, including addiction and mental health therapy.

CARES will turn the VA into a nationwide Health Maintenance Organization (HMO). There are no HMO's in Western SD. Why? There is no profit to be made in rural areas! Treatment of veterans should not depend on the bottom line. Government agencies are not supposed to be monetarily profitable organizations. It is the duty of government to provide services to all veterans, not to profit from them. CARES is another nail in the coffin that is privatization!

The large VISN 23 CARES Steering Committee is a "yes group". It is comprised almost entirely of Management. We had only four Union members, two from former VISN 13 and two from former VISN 14, to speak for all our Bargaining Unit Members. Management members were obliged to create initiatives following recommendations put forth by the VA Leadership. A high-ranking member of the committee once commented that he felt it was unfair to expect people whose jobs would be adversely affected by these initiatives, to bring those initiatives forward. The veteran advocate groups who have representatives on the Steering Committee appear to be convinced that the VA will open the promised Community Based Outpatient Clinics (CBOC) and that the veterans will receive care closer to home. But, once the infrastructure is gone, there is no way to go back to the present situation. Once the work has been contracted out, there is no history of contracting it back.

The CARES Process intends to make the VA a big HMO. I repeat. THERE ARE NO HMO's IN WESTERN SOUTH DAKOTA. CARES will destroy VA Care in rural areas.

Thank you for allowing me to testify today. My name is Jane Nygaard, I am a registered nurse and President of American Federation of Government Employees Local 3669 which represents professional employees at the Minneapolis VA Medical Center.

The CARES process was first initiated after a General Accounting Office report stated that the VA was spending millions of dollars a year maintaining and operating supposedly unneeded and obsolete buildings. At the same time, the VA stated that the way medical services were being provided to veterans was inefficient. VA wanted to address the projected changes not only in the veteran population but also their medical needs and find ways to meet those needs. We were told that the process would objectively evaluate the best way to deliver health care.

Unfortunately the outcome of the CARES initiative does not address any of the above goals. The VA did not take into account the needs of our aging veterans in long term care. In fact the VA itself has projected that it will need an additional 17,000 beds to meet the statutory requirements for veterans in long term care and extended care entitlements in the future. Yet, nothing in the National CARES initiative defines either long term care or acute care as applicable to aging veterans. Nor the draft CARES plan address those with special needs such as PTSD and spinal cord injured or hepatitis c..

VA's own information that was provided to the Senate Veterans Affairs Committee stated the need for the huge number of additional beds that would be needed over the next 20 years. Under the draft CARES plan, the VA will close over 2000 beds in Long Term Care, Domicillary Beds, and Inpatient Psych Beds. If the VA knows that they will need 17,000 beds for Long Term Care in the future then why have they not devised a plan to modify the space they intend to close in order to adequately provide for LTC beds needed in the future?

The real message behind the CARES process seems to be to contract out long term and acute care, as well as the surging demand for inpatient care, and avert the need for comprehensive care for our veterans

The CARES process subverts the most comprehensive, cost effective and well received health care program in the entire world.

The VISNs went through an extensive process that was designed by Central Office that was suppose to be a template as to how the process should work. The VA has stated that they are undergoing revision in their projections of the needs of inpatient and outpatient psychiatric care. They do not know how many veterans need psychiatric care. The data that was used to project our veteran population was based on assumptions of how many veterans might be enrolling in the years to come. Based on "projections" from administrative people we embarked on a new voyage of realigning the VA's. This journey began without taking into account what is happening in health care in our nation right now. Drug costs have skyrocketed, insurance premiums have doubled, and the quality of health care has decreased. In addition, acute care hospital beds have been decreased throughout the nation.

VHA knows that they do not have accurate data to project the needs. Yet the VA, utilizing the CAREs process, continues to propose closing beds. The VA proposed these bed closures despite the fact that the community has also closed their acute care beds. Since the community is also closing acute care and psychiatric beds, it is ridiculous for the VA to assume that veterans will be able to be cared for in the community once the VA has abdicated its responsibility to care for these veterans in VA hospitals. We have troops all over the world who will one day need care. I believe their assumptions are very wrong.

After the VISN completed their plans they were forwarded to Central Office for review. Many of the plans were sent back because they did not accomplish what the goal was. VISN directors were asked to reevaluate the plans they had submitted. They did not meet the expectations that the Administration wanted. Many VISNs were mandated to evaluate a strategy to convert 24 hour facilities to 8 hour a day operations. The impact on the veterans we care for with the closure of Long term and Psych beds at the 18 facilities was not even mentioned. It appears that the desire to reduce beds is being put ahead of the needs of the veterans and that the work of the facility and VISN teams was for naught. After the Undersecretary reviews the plans and makes changes then the Secretary will review and make changes. No one knows what the final outcome will be, but we do know it won't be good for our veterans.

Congress has written letters contesting the process, the reply back from the Secretary was inadequate. Politics is running rampant in this arena, Batavia in New York which was slotted to decrease beds and possibly close was saved and Candiagua will be closed instead impacting over 800 pysch patients it serves and with a projected increase in workoad of 165%. The reason the VA gave was it would be "cost prohibitive". Does the VA really care? It seems that they do not have the interest of our veterans at heart.

In many instances where the VA has slated facilities for closure they have stated that they intend to building or refurbishing buildings on nearby campuses. Unfortunately no funds have been appropriated for this construction. It is estimated that in just one area $92 million would be needed to meet the needs.

Small communities will be greatly impacted by these changes. The public is being misled. They think that they will be able to get care in the public sector but there have been no studies to prove that the private sector even has access for our veteran population, nor do we know if they want to care for our veterans.

The CARES directive states, "CARES will improve quality as measured by access and improve the delivery of health care in a cost-effective manner, while maximizing opportunities and minimizing any adverse impacts on staffing, communities and on other Department of Veterans Affairs (VA) missions." There has been no cost analysis done to ensure that any of the contracting out or the closures would save any money.

If our projections for the needs of our veterans is based on assumptions one would question whether or not an accurate assessment of the community resources not only for the general population but also the specialized needs of our veterans are adequate.

To realign an entire organization based on assumptions seems like a drastic step to take. It appears to me that this is politics as usual. We need to reexamine our commitment to our veterans past, present and future. And what implications this might have for our entire health care deliver system.

VA health care is research based, that it is cost effective, that it is quality health care and why would we want to destroy that by this CARES process.

I think that this process was inaccurate, ineffective and does not serve the needs of our veterans, the communities in which they live and the people who serve them.

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CARES Initiatives VISN 23

COMMENTS ON THE DRAFT NATIONAL CARES PLAN FROM PATRICK RUSSELL, PRESIDENT VA COUNCIL 259

CARES Plans

The Draft National CARES Plan fails to address the expected demand for veterans' long-term and extended care needs. The Commission must be urged to correct this glaring defect in the objectivity and sufficiency of the Draft National CARES Plan.

Introduction:

I am Patrick Russell, President of the American Federation of Government Employees, Local 1539 representing approximately 300 federal employees at the Hot Springs VA Medical Center in Hot Springs, South Dakota. The Hot Springs VA Medical Center serves veterans with a 13-bed inpatient unit, including two beds designated as intensive care, outpatient services, domiciliary care, emergent care and dialysis.

I am also President of the AFGE 8th District National VA Council 259 representing 9,000 Veterans Health Administration, Veterans Benefits Administration and National Cemetery employees from twelve VA facilities in Minnesota, North Dakota, South Dakota, Iowa and Nebraska. Some of the services provided by these employees include outpatient clinics, inpatient care, specialty care, research and development, nursing home care, spinal cord injury units, veteran's benefits and death benefits.

CARES Public Hearings

VA medical centers have seen the market plans and planning initiatives for their VISNs and facilities, which were submitted to the Under Secretary for Health earlier this summer. In some cases where the Draft National CARES Plan proposes a facility closure, it differs from the initial VISN market plans and planning initiatives.

The CARES Commission is charged to "provide objectivity, bring an external perspective to the CARES planning process, and make specific recommendations to the Secretary regarding the realignment and allocation of capital assets necessary to meet the demand for veterans health care services over the next 20 years. In making its recommendations, the Commission will focus on the accessibility and cost effectiveness of care to be provided, while ensuring that the integrity of VA's health care and related missions are maintained, and any adverse impact on VA staff and affected communities is minimized."

Points of Concern

- The CARES plan means the ***destruction of thousands of good jobs*** held overwhelmingly by veterans — which will increase the number of indigent veterans needing care and housing. Jobs at veterans' facilities are some of the best jobs in any community — they have good pensions, health insurance, regular salaries, training and career development potential. The workforce is diverse.

Commitment to veterans is a top motivator of this workforce. The same will not be true in private facilities where veterans will be a minority and no one will consider their special problems and/or needs.

- The private sector nursing home industry trade association estimates the cost per patient for long term care will exceed $100,000 per year in the next decade. The not-for-profit veterans' system can provide superior care to veterans for a lower cost. Private nursing homes are notorious for under-staffing and failing to provide any continuity of care since turnover is very high and morale very low. The constant pressure for profits in the industry makes patient care a low priority—making money is the highest priority. This is not the standard of care our veterans deserve.

- Inpatient psychiatric beds are being reduced and **access to care is ALREADY** being reduced and access to care is ALREADY being **denied** due to lack of in-house capacity. Additional beds and space are needed to establish and maintain the full continuity of care for psychiatric care for veterans in facilities throughout VISN 23 and the nation.

- The VA says it wants to use "Enhanced Use Leases" when they respond to our charge that they have no plan to meet veterans' long term care needs. There is no data that show that the private sector will be able to cover VA's needs through enhanced use leases. Regardless of whether they materialize, they will not be the same thing as veterans-only facilities that guarantee veterans access.

The Draft National CARES Plan fails to plan to meet the increasing demand for long-term care services in 2012 or 2022.

CARES is supposedly data driven but the CARES plans exclude data on what the Under Secretary for Health, Dr. Robert Roswell, has testified is "one of the major driving forces in the design of the VA health care system." **The Draft National CARES Plan fails to address the expected demand for veterans' long-term and extended care needs**. The Commission must be urged to correct this glaring defect in the objectivity and sufficiency of the Draft National CARES Plan. How can the Commission confidentially recommend that the proposed Draft National CARES Plan meets the demand for veterans' health care services over the next 20 years if it does not fully address the long-term and extended-care needs of elderly veterans?

The data for the next 20 years is clear – the VA needs additional capacity to provide for the expected long-term care needs of veterans.

VA readily acknowledges that the number of veterans whose age is 75 and older will increase from 4 million to 4.5 million by 2010. The VA and the General Accounting Office (GAO) estimate that the veterans' population most in need of nursing home care—veterans 85 years old or older—is expected to triple to over 1.3 million by 2012 and remain at that level through 2023. Veterans, whose age is 85 or older, are especially likely to require either institutional long-term care or other types of home-based geriatric services as well as health-care services of all types.

Because the prevalence of Alzheimer's disease and other dementia rapidly increases with age, we can expect that by 2012 nearly half a million veterans will be age 85 or older and have Alzheimer's disease or other dementia. By 2010, some 2.9 million veterans, whose age is 75 or older, are likely to have Alzheimer's disease or other dementia.[1]

[1] AFGE estimates based upon GAO and VA projections of veterans age 75 and older and May 2003 testimony from the Alzheimer's Association before the House Veterans Affairs Committee stating that the "prevalence of Alzheimer's disease increases rapidly with age, from about 3% of people age 65 to 74, to 19% of those age 75-84, and 47% of those age 85 and older."

- AFGE's over-arching, general "concern" is that the recommendations fail to take account of the fact that the population of elderly veterans will grow by 500,000 over the next 7 years, and the number of very elderly veterans (age 85-plus) will triple to over 1.3 million for at least the next 20 years.

VA's own projections are that it will need more than 17,000 beds to meet the statutory requirements for veterans' long term and extend care entitlements.

The rapid rise of elderly veterans will mean VA must plan to have the capital assets to provide them with needed long-term and extended-care services. According to the VA's FY03 VA Enrollee Health Care Projection Model, the average daily census of nursing home beds is expected to increase by 17,357 beds from FY 2001 to FY 2022.[2] This projection is based upon a majority of Priority 1a enrollees turning to the VA for the long-term care benefits that they are entitled to under the Veterans' Millennium Health Care Act. **The Draft National CARES Plan fails to address VA's need for more than 17,000 additional nursing home care and extended care beds.**

> *The implication of the CARES plan is that none of these veterans will receive long term care at VA facilities. Rather, their care will be privatized and they will not have the benefit of specialized, Veterans '-only facilities. Providing Veterans care at Veterans 'facilities was a* ***SOLEMN PROMISE that CARES tries to break.***

- Privatization of veterans' long-term care -- either for those with dementia or psychiatric problems — is neither cost-effective nor consistent with the promise of lifetime care our nation has made to our veterans population.

- Closing VA facilities that can be refurbished to meet the long term care needs of the large and growing population of elderly veterans wastes precious dollars that should be used for veterans.

Privatization of more than 17,000 nursing home-care and extended-care beds will not enhance veterans' care.

We recognize that VA may counter that the number of nursing home beds needed by FY 2022 is inaccurate and the projections are being revised. If this is the case, then the CARES Commission should wait until VA revised its projections and justified why the original projections of more than 17,000 additional beds are incorrect. Assuming that the projections are off by 50% that still means that the VA needs to have the in-house capacity for 8,500 additional beds. How can the Draft National CARES Plan propose closing and downsizing facilities unless it accounts for even 8,500 new nursing home care beds?

The VA may claim that the proposals to use enhanced lease agreements with private developers will provide veterans with more than 17,000 nursing home and extended care beds that are needed. The VA has yet to develop even one site with an enhanced lease to provide assisted living facilities or nursing home care for veterans. It is incredulous to risk the predicted exponential need for veterans' long-term care on this unproven approach to accessing care.

The VA may also claim that it will provide the more than 17,000 additional nursing home and extended care beds through privatization. In testimony before the House Veterans Affairs Committee, the VA Under Secretary for Health has explained that the projected peak in the number of elderly veterans during the first decade of this century will occur approximately 20 years in advance of that in the general U.S. population. It is unlikely that the private sector will have the capacity to meet the demand for care by veterans.

[2] http://www.va.gov/vhareorg/enroll02/enrlfy03/F03_ELDA_Sectn_VI_LTC.pdf (Page 3 of Section VI of FY03 VA Enrollee Health Care Projection Model.)

It is also unlikely that the private nursing home industry will uniformly provide veterans with the high quality of care they deserve. According to a July 2003 GAO report, one in five nursing homes nationwide (about 3,500 homes) had serious deficiencies that caused residents actual harm or placed them in immediate jeopardy and needed more oversight from the Centers for Medicare and Medicaid Services (CMS).[3] The GAO has concluded that the VA is less equipped than CMS to adequately monitor quality standards and the care provided to veterans through national or local contracts.[4] The GAO found that VA's "monitoring of community nursing home oversight is less diligent." Only 4 of the 10 VA Medical Centers that GAO reviewed reported conducting the required annual inspections, and only 4 of 10 generally made required visits to veterans." The VA cannot perform adequate oversight to ensure veterans receive adequate and safe care from the current limited level of privatized nursing home care; we do not believe that planning to contract out 17,000 additional nursing home-care beds will enhance veterans health care in the future.

> *The CARES Commission must ensure that the Draft National CARES Plan enhances veterans' access to long-term and extended care.*

The CARES Commission's review of the Draft National CARES Plan should be guided by basic questions:

- **Is it good for veterans?**
- **Does it contribute to improved health care delivery?**
- **Will it effect a practical result?**
- **Does it safeguard the taxpayers' interest?**

Clearly it is bad for veterans for the VA to plan to reduce beds and close facilities when the plan does not take into account the single largest factor that will shape veterans health care in the next two decades. The Under Secretary for Health's Draft National CARES Plan is not good for veterans, because it proposes closing facilities based upon the projected enrollment demand that excludes projections for the long-term care demand.

The current Draft National CARES Plan **is not good for the delivery** of health care to veterans if the VA does not plan for space to provide adult day health care or respite care. According to recent GAO testimony, more than half of VA's facilities do not offer four of the required non-institutional long-term care services (adult day health care, respite care, and home-based primary) and geriatric evaluation at all or only offer such services in parts of the geographic areas they serve.[5]

The **practical effect** of not including long-term and extended-care space and bed projections in the Draft National CARES Plan is that the VA will not be adequately positioned to provide veterans with the full continuum of care they need as elderly and frail war heroes. Rather than planning for the in-house capacity necessary to meet the rising demand for long-term and extended care, the VA will either deny veterans such care or be forced to rely on the private contractors.

By leaving no option but to privatize veterans' long-term and extended care, **the VA eliminates any leverage to save the taxpayer money.**

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[3] *Nursing Home Quality: Prevalence of Serious Problems, While Declining, Reinforces Importance of Enhanced Oversight*, GAO-03-561 (July 15, 2003).

[4] *VA Long-Term Care: Oversight of Community Nursing Homes Needs Strengthening*, GAO-01-768 (July 27, 2001).

[5] *VA Long-Term Care Veterans' Access to Noninstitutional Care Is Limited by Service Gaps and Facility Restrictions,* GAO-03-815T (May 22, 2003).

The Draft National CARES Plan fails to plan to meet the space and bed needs to provide veterans with inpatient and outpatient psychiatric care.

While the VA claims that its plan is data driven, **the Draft National CARES Plan states that its mental health outpatient and inpatient psychiatry projections are "undergoing revision" and "should be available for next year's strategic planning cycle**."[6] Nonetheless, the Draft National CARES Plan proposes numerous realignments and reductions in beds that directly impact the VA's ability to provide veterans with serious mental illness with the continuum of health care they need.

The VA accedes that it is not meeting its current mandates to provide mentally ill and homeless veterans with the continuum of care they desperately need.[7] According to the Under Secretary's written response to congressional questions, the VA may be as much as 20% below population-based needs for inpatient psychiatric beds.[8] In addition, 69% of VA facilities do not have any current inpatient capacity for the treatment of psychiatric geriatric patients who need specialized long-term and extended care.[9] VA estimates that for FY 2004 to meet the current demand for care, approximately 396 additional residential rehabilitation beds are needed nationwide to serve the current needs of 5,000 seriously mentally ill veterans.[10] VA also projects that VA would need a minimum of 250 additional domiciliary care beds for homeless veterans in FY 2004 to provide an additional 785 homeless veterans with residential treatment.[11]

The Under Secretary's recent response to congressional questions on access to mental health services reflects a connection between inpatient medical and psychiatric care and the effectiveness of treatment for substance abuse. While many patients are successfully stabilized and maintained in outpatient programs, the use of inpatient stabilization and residential rehabilitation is critical to reduce subsequent re-admissions and to treat patients with greater substance-use severity.[12]

Despite the absence of CARES data projecting inpatient and out patient psychiatric demand and the clear recognition that VA is not meeting veterans demand currently, **the VA has proposed a Draft National CARES Plan that does not adequately ensure that the VA will have the beds and space needed to care for seriously mentally-ill and homeless veterans.**

The Draft National CARES Plan fails to plan for additional pharmacy space and Consolidated Mail Outpatient Pharmacies (CMOPs) to meet the growing demand from veterans for prescription drugs.

The VA estimates that the increase in Priority 7 and 8 veterans is in large part due to VA's prescription drug benefit. The VA's recent change in policy to permit veterans to fill non-VA physician prescriptions is likely to increase veterans' use of the VA pharmacy. The VA currently has seven regional CMOPs which process

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[6] *Draft National Cares Plan,* Chapter 5, page 6 footnote 5 and Chapter 6, page 5 footnote 5. *See also,* Chapter 7, page 4 Future Directions stating "There was general consensus that the mental health projections needed to be further studied and refined."

[7] Under Secretary for Health's response to post hearing questions concerning July 24, 2002 Senate Veterans Affairs Committee hearing on "Mental Health Care: Can the VA Still Deliver?"

[8] Id.

[9] Id.

[10] Id.

[11] Id.

[12] Id.

approximately 20 million prescriptions a year above their workload design.[13] GAO estimated in FY 2002 that VA's CMOPs would likely cost the Department of Defense less than a commercial mail-service pharmacy and would save taxpayers at least $45 million in current dispensing costs.[14] The Draft National CARES Plan should plan on the space needs to add additional VA CMOPs to meet the veterans projected prescription drug demand.

The closures proposed in the Draft National CARES Plans are not based upon decreasing numbers of veterans but lack of in-house capacity to meet the rising demand.

> *In many instances where VA is closing or downsizing facilities, patient workload is actually projected to **increase**.*

For example, the area served by the Canandaigua facility is projecting a 165% increase by 2012 in the demand for specialty services. Nevertheless, Canandaigua is slated for closure. VA contends that meeting this increased demand at the Canandaigua campus would require extensive renovations, and is therefore "cost prohibitive." The VA should take its funds and care for the increase in the veteran population in-house.

The Draft National CARES Plan relies on privatization and DOD collaborations rather than on investments VA's projected in-house capacity.

Instead of spending resources on additional VA facilities to meet the needs of the future, VA has decided to spend these resources on contracting out veterans' healthcare. The Canandaigua example cited above is also an example of **VA's intention to contract out additional workload**. The original VISN plan called for the current (2001) workload to continue at Canandaigua and the Rochester OPC, but anything beyond that level would mean contracting for services with non-VA healthcare providers. However, the National Draft Plan, which calls for facility closure, would require VA to contract for all care in the Canandaigua market.

Gulfport, Mississippi is an example of where VA is seeking to shift the care of veterans from the VA system to the Department of Defense (DOD). The VISN considered moving all services from the Gulfport campus to the VA campus in Biloxi. However, the VISN recommended moving only some of the services to Biloxi, while the remainder would be moved to Keesler Air Force Base. The National Draft plan adopted this recommendation.

> *The CARES plan says that it includes both closures and expansions. Nothing should be closed until all the expansions are funded, built, and operational. To close facilities without making sure that expanded facilities are funded, built, and operational elsewhere risks depletion of the veterans' system's capacities. When capacity is lost, the VA will be able to privatize and say, "no one will lose his/her job."*

The Draft National Cares Plan calls for **relocating ALL inpatient beds in Knoxville, Iowa** to the Des Moines VA. In order for the Des Moines VA to accommodate the increased workload, it must be enlarged and renovated. The CARES Plan would close the services in Knoxville before any renovations at Des Moines. The money for reconstruction has not been allocated, yet services will be eliminated in Knoxville.

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[13] http://www.presidentshealthcare.org/pdffiles/5Pharmacy.pdf

[14] May 25, 2000, Statement of Steve P. Backhus, GAO Director, Veterans' Affairs and Military Health Care Issues, Health, Education, and Human Services Division, before the House Veterans Affairs Committee, Oversight and Investigations Subcommittee Hearing on Joint Procurement of Pharmaceuticals by VA and DOD.

The Draft National CARES Plan calls for **reducing the number of inpatient beds in Hot Springs**, South Dakota from the current 13-bed inpatient unit to a 5-bed 'critical access' unit. A critical access designation means that veterans will be transported after a 96-hour stay. They will be sent 100 miles farther away to another VA hospital or to a private sector hospital in Rapid City. Family members will be forced to drive farther to visit their hospitalized veteran. Once the current resources are overtaxed, veterans will be hospitalized in private sector hospitals at an increased cost to the taxpayer. A subsequent closure of all inpatient care at the Hot Springs Medical Center, which is foreseeable if this course continues, will also force the facility to eliminate the outpatient surgery and dialysis units.

Rural veterans are being forced to drive farther for their care. As the inconvenience for these veterans increases they will either seek care through other sources or not seek care at all. As the market demand decreases the VA will continue to make cuts resulting in less care. A delay in care is analogous to a denial of care. Veterans will die because they did not or could not receive care in a timely manner.

Conclusion:

CARES is NOT about moving facilities and capacity to locations where the veterans live. It is about closing down facilities and reducing capacity so that veterans' care can be privatized and veterans no longer have access to specialized, veterans'-only facilities and care. It is about moving health care from rural settings to urban areas. If the logic of the CARES initiative continues, rural veterans will have to leave their homes to relocate in large urban areas if they wish to receive the care promised by the American government.

Privatization will cost more and veterans will get less—lower quality, less continuity, less specialized care, less commitment, less recognition. Thousands of veterans will lose their jobs. Taxpayers will lose. Veterans will lose. Federal employees who have devoted their lives to the care of veterans and the promotion of their interests will lose. But private nursing home operators and contract inpatient care will win big.

August 27, 2003

Patrick M. Russell, President VA Council 259 — Date